Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402